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FISCAL IMPACT STATEMENT

LS 7409 **NOTE PREPARED:** May 4, 2007
BILL NUMBER: SB 566 **BILL AMENDED:** Apr 28, 2007

SUBJECT: Medicaid Claims and Psychiatric Facility Funding.

FIRST AUTHOR: Sen. Dillon **BILL STATUS:** Enrolled
FIRST SPONSOR: Rep. C. Brown

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State & Local
X **DEDICATED**
X **FEDERAL**

Summary of Legislation: This bill requires an insurer to accept a Medicaid claim for services provided a Medicaid recipient for three years after the date the service was provided. The bill specifies the circumstances in which a Medicaid claim may not be denied by an insurer. It also states that notice requirements may be satisfied by electronic or mail submission (current law provides only for certified or registered mail). The bill further requires an insurer to accept the state's right of recovery and assignment of certain rights as required by federal law.

The bill adds certain less restrictive settings to the definition of children's psychiatric residential treatment services.

Coordination of Benefits Study: The bill requires the Office of Medicaid Policy and Planning (OMPP) to conduct a study of Medicaid claims eligible for payment by a third party. The bill further provides that if the study by OMPP reveals a percentage of 1%, OMPP shall implement an automated procedure for determining whether a Medicaid claim is eligible for payment by a third party before payment.

Notification Changes for the Maximum Allowable Cost (MAC) Schedule: The bill allows OMPP to implement a change in the maximum allowable cost schedule for prescription drugs 30 days after OMPP posts the changes on OMPP's Internet web site. (Current law requires 45 days before the change may be effective). The bill allows a pharmacy to determine not to participate in the Medicaid program as a result of a change in the schedule if the pharmacy notifies the office within 30 days of the change in the schedule taking effect.

State Mental Health Charges: The bill changes the way charges are set at state mental health institutions.

It also repeals provisions concerning the per capita cost of treatment at state mental health institutions and the per capita cost of outpatient services.

Effective Date: Upon passage; July 1, 2007.

Summary of Net State Impact: Reductions in the notice requirement for changes to the Maximum Allowable Cost schedule for Medicaid prescription drugs is estimated to result in savings of $1.2 M in state and federal dollars, or about $450,000 in state General Funds.

Extending the length of time for Medicaid third-party recoveries is estimated to provide for an additional $3.2 M in state and federal reimbursements, or $1.2 M in state General Funds.

Revisions in the structure of charges for services delivered by state mental health institutions is estimated to result in additional annual revenue of $3 M.

Explanation of State Expenditures: *Coordination of Benefits Study:* Before January 1, 2008, the bill requires the OMPP to examine six and one-half years' of Medicaid claims to determine and recover claims that were eligible for payment by third parties other than Medicaid. The bill allows the Office to, after notice and hearing, impose a fine of up to $1,000 for refusals to provide information concerning an eligibility request for a Medicaid recipient. If the study determines that at least 1% of the claims were payable by a third party, OMPP is required to implement a procedure to improve the coordination of benefits between Medicaid and other third-party payers. The procedure, if developed, is required to be automated and must be capable of determining whether a claim is eligible for payment by another party before Medicaid payment is made. The cost of this provision or the potential savings that may be achieved through additional recoveries is not determinable at this time.

Notification Changes for the Maximum Allowable Cost Schedule: The bill would reduce the length of time from 45 days to 30days that OMPP is required to post a notice of changes to the MAC schedule for prescription drugs before the change is effective. The cost savings would depend on the number and magnitude of the changes to the MAC schedule. OMPP has estimated that had this bill been in effect for FY 2006, the state would have saved approximately $1.2 M in state and federal dollars, or about $450,000 in state General Funds.

Costs associated with the distribution of paper notices are assumed by a contractor and are reported to be negligible by OMPP.

The bill would allow pharmacies 30 days to notify OMPP that they will no longer be participating in the Medicaid program as the result of a change in the maximum allowable cost of a drug. (Currently, pharmacies and other enrolled providers must provide 60-days notice to discontinue participation in the program.)

The Medicaid Program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Explanation of State Revenues: *Medicaid Claims for Services - Third-Party Recoveries:* The provisions regarding Medicaid claims for services provided to Medicaid recipients that are or were also covered by another insurer bring the state statute into compliance with provisions of the federal Deficit Reduction Act

of 2005. This provision may result in additional recoveries of Medicaid reimbursements. The Office of Medicaid Policy and Planning has estimated that annually an additional $3.2 M could be recovered. Recoveries are distributed between the state and federal government on the basis of the percentage paid by each. The state General Fund recovery is estimated to be $1.2 M.

State Mental Health Charges: The bill eliminates the restriction that requires state mental health facilities to base their charges on certain per capita costs. The bill would allow for a charge structure that could reflect a patient acuity level, allowing patients that require more services or higher intensity services to be charged accordingly. Conversely, patients with less intensive care requirements could be charged less, rather than being required to pay on an average cost basis. The charge structure would not be limited to the cost, allowing for charges that might include incentives for meeting operational objectives or other management incentives. The fiscal impact of this bill would depend on administrative actions taken to annually set patient charges at each institution.

The Family and Social Services Administration (FSSA) reports that the bill will also allow FSSA to bill Medicare and other payers for prescription drugs based on each patient's drug usage. The new Medicare drug benefit (Part D), which began on January 1, 2006, also provides a new source of reimbursement to state facilities for prescription drugs. Under the bill, FSSA estimates that it will increase reimbursement to the state by approximately $3 M annually.

Background: Each patient (guardian or parent) in a psychiatric hospital or a state school for the developmentally disabled is liable for payment of the cost of treatment and maintenance in an amount to be fixed by the Division of Mental Health and Addiction. The rate varies by institution, whether private pay, or Medicaid, and according to the patient's ability to pay.

See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures: *Children's Psychiatric Residential Treatment:* The bill would provide that services eligible under the program include treatment services in settings other than institutional settings. The bill specifies that children served in alternative settings must be eligible for admission to a residential treatment facility. This may ultimately provide for cost savings to the Medicaid program and the counties if children can receive lower-cost services outside of an institutional setting. It may also allow for more intensive care after a period of inpatient care.

Background: Before the separate PRTS levy was established, counties provided payment for inpatient residential treatment services for children determined to be wards of the court from the county Family and Children's Fund at 100% of the cost. When the PRTS levy was established in CY 2004, the Family and Children's Fund levy was reduced by the amount spent for the inpatient residential treatment services, while the PRTS levy was calculated on what the state Medicaid share of those costs would have been, resulting in a net decrease between the two levies. The separate PRTS levy provided a methodology for leveraging Medicaid funding when available, requiring the county to provide the state share of the Medicaid program cost for all (not just the wards) Medicaid-eligible children under the age of 21 years in the county that are certified for placement in psychiatric residential treatment facilities. The expenditures paid from this county fund can vary widely, especially for smaller counties. Unlike the Medicaid for Wards levy, the PRTS levy does not have a maximum levy limit. The tax levy for the county PRTS fund is based on the budgeted anticipated costs for the county's children's residential psychiatric services that are equal to the state share of the cost of services that are reimbursable by Medicaid, or about 38% of the total cost of the Medicaid services.

Explanation of Local Revenues: *Children's Psychiatric Residential Treatment:* The bill does not influence the amount of local revenue raised for the PRTS since there are no changes to how the levy is determined.

Notification Changes for the MAC Schedule: County-owned hospitals with pharmacies that dispense outpatient prescriptions for fee-for-service Medicaid recipients and county-owned nursing facilities with pharmacies that dispense prescriptions for patients not covered by Medicare Part D could realize a decrease in prescription drug revenue from Medicaid.

State Agencies Affected: OMPP and the Division of Mental Health and Addiction of the Family and Social Services Administration.

Local Agencies Affected: County Auditors and county-owned hospitals and nursing facilities

Information Sources: Deficit Reduction Act of 2005; Department of Child Services; Office of Medicaid Policy and Planning; *Indiana Handbook of Taxes, Revenues, and Appropriations*, Legislative Services Agency, Office of Fiscal and Management Analysis, FY 2006; Willard Mays, FSSA.

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